Frailty briefing

SUMMARY

- Frailty is a useful, broad concept which describes an increasing vulnerability to stressors which is associated with the process of ageing.
- For people at risk of developing frailty there are potentially preventable or modifiable risk factors and in the management of associated long-term conditions.
- Promoting healthy ageing offers a chance to avoid or postpone the onset of frailty.[1]
- Evidence-based methods for robustly identifying frail patients individually in the community need to be uniformly implemented across Sussex. The locally commissioned service in primary care should help achieve this aim and will assist future planning/ delivering frailty appropriate care.
- Health and social care interventions should be implemented promptly once frailty risks have been identified.[2] New models of improving healthy ageing in primary care have been shown to have measurable outcome benefits.[3]

Contents

Introduction:

Why is frailty important?

Frailty has been described as "the most problematic expression of population ageing." [4]

Currently older people with mild, moderate or severe frailty often present to services when in crisis. Early identification of frailty and optimising the care and support for people with multiple long-term conditions [multi-morbidity] can reduce the likelihood, or the impact of crises and promote earlier and better recovery.

Frail individuals can endure extended stays in hospital that worsen their frailty and accelerate their dependency. Frail patients are most likely to have delayed transfers of care out of hospital or spend their last days on a hospital ward.[5]

What does frailty look like? [6]

Frailty refers to a person's mental and physical resilience, or their ability to bounce back and recover from events like illness and injury.

If someone is living with frailty, it doesn't mean they lack mental capacity or are incapable of living a full and independent life. It describes someone's overall resilience and how this relates to their chance to recover quickly following health problems.

In practice being frail means a relatively 'minor' health problem, such as a urinary tract infection, can have a severe long-term impact on someone's health and wellbeing.

What are the implications of frailty?

- cognitive impairment is more common;
- greater risk of falls;
- greater risk of malnutrition;

Frailty has been shown to be a predictor of death and institutionalisation in older people.[7,8,9]

- Frailty is associated with increased health service use, most commonly for hospital admissions and care home admissions.[10,11,12,13] Frailty is associated with approximately double the number of first hospital admissions compared to non-frail individuals.
- Frail individuals are more likely to spend longer in hospital and to be discharged to care homes having been admitted.[14] Care home residents are more likely to be frail than community dwelling people.
- Cognitive impairment is common along with risk of delirium.
- Frail people are also at greater risk of falls and their adverse effects such as fractures, long term dependency and death.[15]
- Frail individuals often have difficulty with eating and absorbing nutrients and consequently can develop malnutrition, which is often unrecognised.[16,17]

Defining key terms

What is frailty?

Frailty is a reduction of the built-in reserves of multiple bodily systems, leading to increased vulnerability.[18] A fall, new drugs, or minor infections can result in a disproportionate deterioration in physical, functional and mental health in a frail person compared to a non-frail person.

Frailty can occur at any age although tends to be associated with ageing. It includes a spectrum of physical, psychological and social deficits which interact with each other and which affect a person's quality of life.[19]

Short film produced by Fusion 48 | youtube.com

The majority of people with frailty have multiple long-term conditions, whereas only a small proportion of adults with multiple long-term conditions are frail.[20]

Frailty is a condition associated with an increased risk of serious deterioration in a person's health. This can present or become apparent as:

- "acute frailty syndromes" – falls, delirium (or acute confusion)
- "off legs" which may result from a relatively minor insult
- higher risk of acute hospital admission
- Death
- Care home admission

How is frailty identified in practice?

Numerous methods are available to identify frailty. A comparison of the relative strengths and weaknesses of each method and context for their use can be found at the Scottish Improvement Hub | ihub.scot.[21]

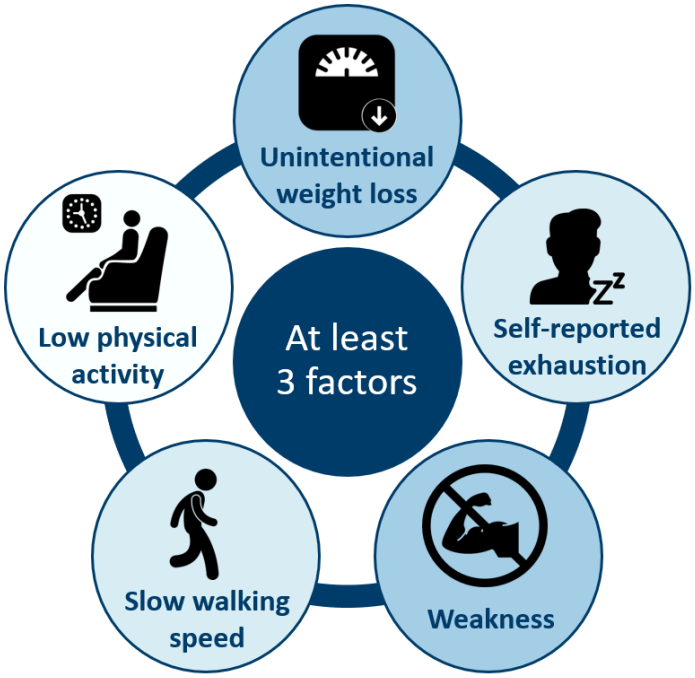
Frailty risk can be considered at a population level, looking back at routine coded data, or from reviewing specific assessments of frailty in individual persons in a clinical context. Methods used for clinical assessment of an individual also depend on whether an assessment is being carried out for an inpatient, or in a community setting. There are also validated, self-assessment questionnaires for use in the community.

Examples of frailty measures[22]

Physical Frailty Phenotype

The Physical Frailty Phenotype [PFP] measures frailty by assessing five features of frailty that are primarily physical in nature—reduced gait speed, muscle strength, body mass, physical activity, and energy levels.

The most widely accepted definition of frailty is based on the co-occurrence of at least three of five features including: unintentional weight loss; self-reported exhaustion; weakness (low grip strength); slow walking speed; and low physical activity.[23]



Electronic Frailty Index

Alternatively, frailty can be defined in terms of an accumulation of deficits in an individual: for example, by using the Electronic Frailty Index eFI. The more deficits you have, potentially the frailer you are. The Electronic Frailty Index is a screening tool to be used in conjunction with clinical judgement.

The eFI relies on looking for 36 specified items (diagnoses, symptoms, sensory impairments, disabilities) in a person's primary care [GP] record. Out of this possible total, the number of deficits a person has accumulated are counted. The proportion [total acquired deficits/total maximum of 36] is defined as the eFrailty Index [eFI].

The eFI enables services and treatments to be targeted on the basis of people's frailty status, rather than their chronological age. This method has been proven to identify risk of hospital admission, care home admission and death.[24]

The eFrailty Index [eFI] has been proven to identify a group of people who are highly likely to be frail. As with any other screening tool, the eFI will identify false positives [people with clinical problems who are not frail] and false negatives [frail people missed by the initial screen].

'Further studies are needed to determine how well physical frailty scores (for example the Physical Frailty Phenotype PFP) and the eFI match in identifying individuals'.[25]

Rockwood Clinical Frailty Scale

Many clinicians in Sussex prefer to use the Rockwood Clinical Frailty Score, a measure of frailty based on clinical judgment.[26,27] This system is in use throughout East Sussex Healthcare Trust.

The Clinical Frailty Scale (CFS) allows clinicians with limited experience in frailty identification and management to identify those with frailty.

The following definitions used in the Rockwood Frailty Scale are referred to in the Sussex PCNs Locally Commissioned Service:

Clinical frailty scale

1	**Very fit**	**People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.**
2	Fit	People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.
3	Managing well	People whose medical problems are well controlled, even if occasionally symptomatic, but often are not regularly active beyond routine walking.
4	Living with very mild frailty	People 'vulnerable'. This category marks early transition from complete independence. While **not dependent** on others for daily help, often **symptoms limit activities**. A common complain is being 'slowed up' and/or being tired during the day.
5	Living with mild frailty	People who often have **more evident slowing**, and need help with **high order instrumental activities of daily living** (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
6	Living with moderate frailty	People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs, **need help bathing** and may need minimal assistance (cuing, standby) dressing.

7	Living with severe frailty	**Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
8	Living with very severe frailty	Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
9	Terminally ill	Approaching the end of life. This category applies to people with a **life expectancy <6 months**, who are **not otherwise living with severe frailty**. Many terminally ill people can still exercise very close to death.

Source: Rockwood K, Song X, MacKnight C, et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495

How are general practices expected to assess frailty?

Routine frailty identification in practice populations for patients who are 65 and over can be undertaken using the eFI score.[28] Having identified a list of people who may be frail by searching the GP records, a clinical assessment should follow. [This is what appears in the NHS GP contract].

The eFI is used to screen for mild, moderate, and severe frailty. This can then be followed by health and social care interventions:

- health promotion and exercise for people with mild frailty
- case management for people with moderate frailty and
- a comprehensive geriatric assessment [CGA] for people with severe frailty[29]

A CGA enables the design of a coordinated, integrated plan for long-term treatment and follow up. As part of this process, severely frail patients should receive a falls assessment and a medication review.

How effective the process of undertaking CGA in the community is, is unclear. This is because there is so much variation in how community-based, complex interventions are implemented and evaluated.[30] Comprehensive Geriatric Assessment can improve health outcomes in hospital. A systematic review of evidence regarding community management is ongoing.[31]

Rates of coded frailty diagnoses, medication reviews, and referrals for falls assessments show variation between practices nationally and locally.[32]

Key outcomes

In view of the potential for frailty to be associated with adverse health outcomes one of the objectives of healthy ageing is to prevent its onset. Frailty is not an inevitable consequence of ageing.

What can be done to prevent frailty?

Strong system leadership is needed for healthy ageing programmes and managing and preventing frailty.[33]

Social inequalities have a major negative effect on healthy ageing.[34]

Inequalities in Frailty Risk Factors

Two UK cohort studies, the Whitehall II and UK Biobank studies have looked at frailty at a population level.[35,36] Both identified substantial inequalities in the occurrence of frailty. These studies show that long-term conditions and their risk factors are often antecedents of frailty.

In the Whitehall study fewer than 2% showed evidence of frailty under the age of 65, increasing to more than 10% at 75 years or older. Frailty was more frequent in women, ethnic minority groups and those with low employment grade. Participants who had long-term conditions, or lifestyle risk factors for long-term conditions at the age of 50 years, were more likely to develop frailty in later life, and these characteristics largely accounted for the inequalities in frailty observed in later life.

Multiple long-term conditions were strongly associated with frailty in the UK Biobank study data in participants in the study with four or more long term conditions.

Obesity in midlife was associated with frailty in both studies, suggesting that targeting modifiable risk factors at midlife might reduce the occurrence of frailty at later ages.

Socio-economic deprivation and geographical variation of frailty

The English Longitudinal Study of Ageing (ELSA) has been used to estimate the district-level prevalence of frailty.[37] There are higher rates of frailty in people aged over 50 years in areas of higher deprivation. This includes the more deprived areas of cities and coastal towns, Figure 2.

The proportion of the population in East Sussex aged over 60 living in poverty [based on the Index of Deprivation in Older People Index, the IDAOPI index] ranges from 2% in areas in Wealden

District to 48% in areas in Hastings Borough. This is consistent with the pattern of frailty shown in Figure 2.

Protective factors

The following factors can reduce the risk of frailty. However, these protective factors are unequally distributed in the population.

Healthy ageing can reduce the risk of frailty.[38] This section is adapted from an Age UK evidence review.

- Stopping smoking: smoking increases the risk for diseases such as lung cancer, Smoking accelerates the rate of decline of bone density, muscular strength and respiratory function.
- Maintain good oral health: dental caries, periodontal diseases, tooth loss and oral cancer cause other systemic health problems. They can reduce self-confidence and quality of life. Poor oral health is associated with malnutrition.
- Avoiding misusing alcohol: while older people tend to drink less than younger people, metabolism changes that accompany ageing increase their susceptibility to alcohol-related diseases. Older people also have greater risks for alcohol-related falls and injuries, as well as the potential hazards associated with mixing alcohol and medications.
- Healthy Nutrition: eating and food security problems include both under-nutrition and excess energy intake.
- Malnutrition can be caused by limited access to food, socio-economic hardships, a lack of information and knowledge about nutrition, poor food choices (e.g. eating high-fat foods), disease and the use of medications, tooth loss, social isolation, cognitive or physical disabilities that inhibit one's ability to buy foods and prepare them, emergency situations and a lack of physical activity.

- Excess energy intake greatly increases the risk for obesity, chronic diseases and disabilities as people grow older. Insufficient calcium and vitamin D is associated with a loss of bone density in older age and consequently an increase in painful, debilitating bone fractures.
- Avoid overuse of multiple medications: Medications are sometimes over-prescribed to older people. Adverse drug-related reactions and falls associated with medication use are significant causes of preventable hospital admissions.
- Consideration of psychological factors: Declines in cognitive functioning are triggered by disuse (lack of practice), illness (such as depression), behavioral factors (such as the use of alcohol and medications), psychological factors (such as lack of motivation, low expectations, and lack of confidence), and social factors (such as loneliness and isolation).
- Suitable physical environments: older people who live in an unsafe environment are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems. Hazards in the physical environment can lead to debilitating and painful injuries among older people.
- Vision and hearing loss: preventing avoidable sight and hearing loss are important issues and are discussed in separate JSNA briefings.

What can be done about established frailty?

Adverse effects of frailty can be mitigated, for example:

- Falls risks can be reduced in the home
- Timely medication review can reduce risk of Adverse Drug Reactions, drug interactions, and non-adherence with medicines

Other evidence-based interventions include:

- Proactive and targeted case finding
- Exercise and nutrition interventions
- Integrated healthcare: person-centered, single point of care
- Housing with extra care and support
- Use of electronic notes and telecare

National and Local Policy and Strategy:

National policy encourages the systematic, early recognition and assessment of frailty in all patients. This involves clinical practice moving away from disease-focused specialties which have largely provided non-integrated, reactive care in the past.

Future health and care policy aims for greater patient-centred care with comprehensive, multi-disciplinary geriatric assessment, and proactive-patient centred planning. These concepts are summarised in the following reports:

- NHS England Safe compassionate care for frail older people using an integrated care pathway.
- Quality care for older people with urgent and emergency care needs
- King's Fund: making our healthcare systems fit for an ageing population
- British Geriatric Society: commissioning guidance high quality healthcare for older care home residents
- Multimorbidity: clinical assessment and management | Guidance | NICE [39]
- NHS RightCare Frailty Toolkit is designed to support systems to understand the priorities in frailty identification and care, and key actions to take.

The NHS Long Term Plan sets out an evidence-based framework of care for older people with frailty to be delivered through the national Ageing Well programme.

The plan focuses on delivering integrated personalised care in communities and describes three inter-related service models to address the needs of older people.

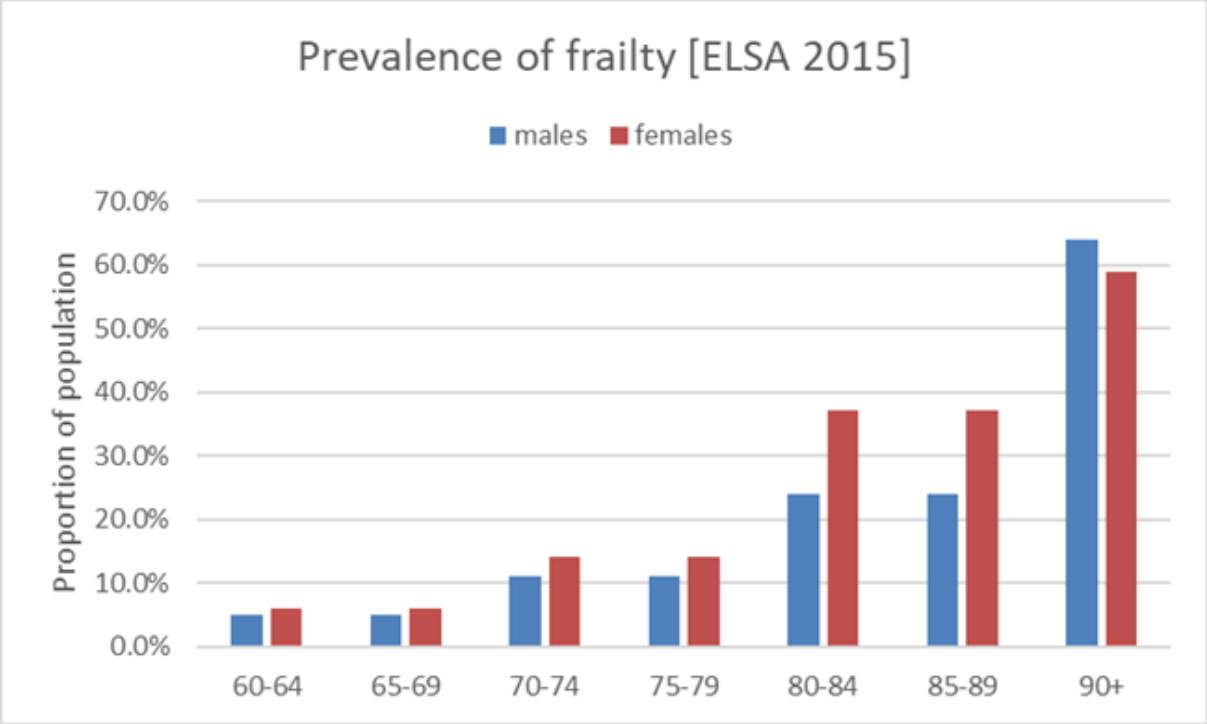
1. **Community multidisciplinary teams** to target the moderate frailty population. This group are considered to be the most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.
2. **Urgent Community Response-[UCR]** to provide a crisis response and community recovery service for older people who are at risk of unwarranted stay in hospital and whose needs can be met more effectively in a community setting.
3. **Enhanced health in care homes. [EHCH]**. This recognises that care homes are an increasingly important place for end-of-life care.

National and local context - known health inequalities

Age:

The prevalence rates of frailty increase with age, Figure 1.

Figure 1 Increasing prevalence of frailty with age



Source: PH department ESCC. ELSA 2015 [40]

Equalities groups:

Specific local analysis would be required to understand the prevalence of frailty and specific local issues affecting persons in the following groups: ethnic minorities; transgender persons; sexual orientation; and religious groups.

Race & Ethnicity: not known [would require local analysis of frailty prevalence and severity by ethnic group]

Gender: Women have greater risk of developing frailty compared to men. Coupled with a 40% loss of mobility in women between the ages of 75 and 85, this makes older women particularly vulnerable to the effects of both frailty and disability.

Sexual orientation: not known [would require local analysis of frailty prevalence by sexual orientation]

Disability: frailty is associated with multiple Long-Term Conditions but can occur in the absence of these.

There is overlap between frailty and physical disability – many people with frailty also have disability, but lots of people with a long-term disability do not have frailty. Frailty may be the cause of disability in some patients and the consequence in others.

Malnutrition: Frail individuals often have difficulty with eating and absorbing nutrients and consequently can develop malnutrition which is often unrecognised. Assessment of frailty also includes checking nutritional status, for example by using the Malnutrition Universal Screening Tool (MUST).

Transgender: not known [would require local analysis if this group is more frail]

Religion / belief: not known [would require local analysis if some groups more frail]

Carers: Most carers in East Sussex are of working age, although 28.5 per cent are aged over 65.[41] Although the proportion of those aged 65 and over providing unpaid care is lower than the proportion of working age, people in this age group were more likely to be providing 50 or more hours unpaid care a week.

When considering unpaid caring responsibilities, the percentage reporting poor health in East Sussex increases with age and is highest in those who provide 50 or more hours a week unpaid care.[42]

As the population ages, the number of older people who are informal carers is growing, particularly in those aged 85 and over. This group may not recognise themselves as carers, and may be at increased risk of isolation, loneliness and mental health issues.[43]

Carers UK identified the significant negative impacts on mental health due to caring, with around 70% of carers experiencing mental health issues, such as stress or depression due to caring. Around 80% of carers report feeling lonely or socially isolated due to their caring role.[44,45]

Pregnancy, maternity, breastfeeding: N/A

Marriage / civil partnership N/A

Figure 2 Estimated prevalence of frailty among people aged over 50 in each local authority in England, 2020

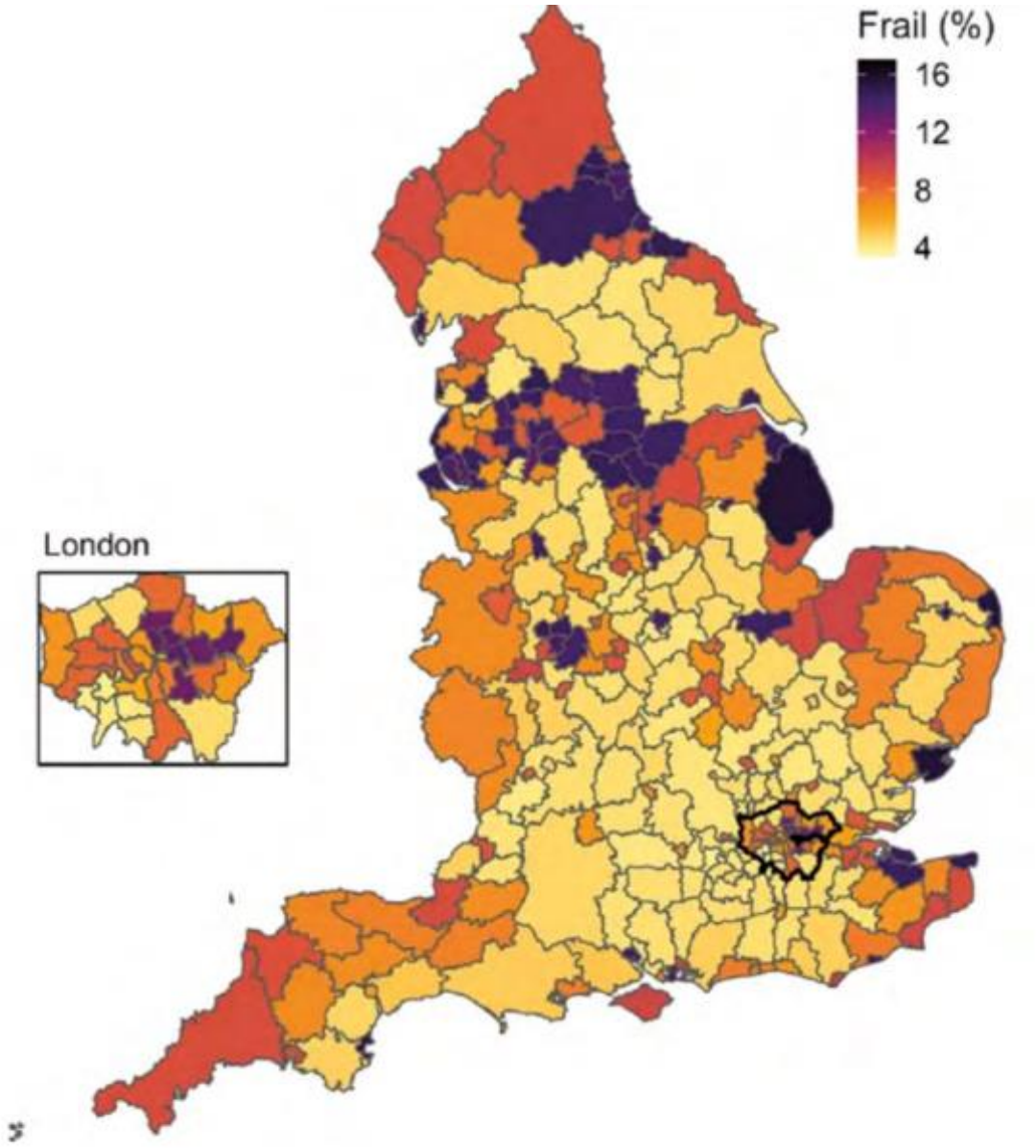


Image source: Sinclair and others, The Journal of Frailty & Aging (2022)

Service provision and use:

The East Sussex Hospitals Trust [ESHT] Transformation Programme:

The ESHT transformation programme is a multi-year programme to make ESHT (and East Sussex) the "Best at Frailty" by improving how we recognise Frailty, work together on aligned/integrated pathways delivering personalised support that enhances quality of life for those with Frailty such

that: a) patient and carer experience improves, b) per head of population with frailty, there is less frequent need to access acute care, c) quality of care and life increases.

The East Sussex Hospitals Trust [ESHT] frailty practitioner service:

The service takes referrals from GP's, other community services and the local acute hospitals. The service aims to improve the lives of older people who are 75 years and over and who have either been admitted to hospital three times or more in the past year, or have recently been discharged from hospital.

Patients are visited in their own home and a comprehensive clinical assessment undertaken which includes memory screening, a medications review and a discussion about wishes and preferences for their future care. The assessment is discussed with a Consultant Geriatrician and information is shared with the GP and other relevant professionals including the ambulance service with the individual's consent. A follow up meeting is arranged to ensure that the plan is helping to meet the patient's desired outcomes.

The service is a short-term service and patients can expect between one and six visits over a period of 4 to 6 weeks depending on their need. As part of the agreed plan and with a view to provide ongoing support the service may refer patients on to other professionals who would be involved with their care over a longer period.

The Frailty Practitioners are all experienced healthcare professionals with an interest in the care of the older person living with frailty. They have experience of working in both hospital and community settings and of undertaking holistic assessments.

The Frailty Practitioner team enable a patient to discuss their health and social situation, with friends or family present, if they wish, to ensure that their wishes are heard and a plan is made for their care. If a friend, or family member supports the patient's care the service will offer a Care for the Carers referral for their assessment.

The aim is to prevent unnecessary or prolonged stays in hospital. The service aims for patients to receive the appropriate level of care in the place of their choice.

Predicting Future need:

How many people in East Sussex are estimated to be frail now and in the future?

There are an estimated 22,000 people aged 65 and over living in East Sussex with moderate or severe frailty in 2023.[46] The number of moderate and severely frail persons in East Sussex is expected to increase to over 25,000 people by 2028.

Table 1 shows how the estimated prevalence of frailty in East Sussex Districts and Boroughs in persons aged 65 and over changes between 2023 and 2028.

The estimates here use prevalence estimates of: mild 0.35 [35%], moderate 0.12 [12%] and severe 0.03 [3%] frailty categories. These are based on a study which was validating the development of the eFI.[47] The estimated severe frailty prevalence used here is under half that currently quoted on the British Geriatric Survey (BGS) website which states: 7% of the population over 65 years are likely to be severely frail.

The BGS website also quotes coded GP contract data from 2018 diagnoses that the prevalence of severe frailty was about 3.2% of the 65+ population. This was an average of 46 patients per GP practice or 0.6% of the average practice list.

Table 1 Estimated prevalence of frailty: East Sussex Districts and Boroughs **in persons aged 65 and over** 2023 to 2028.

		Mild	Moderate	Severe
Proportion with frailty		0.35	0.12	0.03
	Population in 2023			
Eastbourne	26,000	9,100	3,100	800
Hastings	19,200	6,700	2,300	600
Lewes	27,500	9,600	3,300	800
Rother	31,300	11,000	3,800	1,000
Wealden	44,400	15,600	5,300	1,300
East Sussex	148,400	52,000	18,000	4,500
		Mild	Moderate	Severe
Proportion with frailty		0.35	0.12	0.03
	Population in 2028			
Eastbourne	29,200	10,200	3,500	900
Hastings	21,800	7,600	2,600	700
Lewes	30,500	10,700	3,600	900
Rother	34,900	12,200	4,200	1,000

Wealden	51,200	17,900	6,100	1,500
East Sussex	167,600	58,600	20,100	5,000

Source: ESiF and parameter estimates from Ref.[48]

Population estimates are rounded to the nearest 100.

There are no robust epidemiological data yet available to describe the prevalence of frailty in assisted living environments [care homes, extra care living facilities].[49]

What has been the effect of the pandemic on the prevalence of frailty?

The coronavirus (COVID-19) pandemic, and in particular national lockdowns, may have led to an increase in the prevalence of disability and frailty. This is because of the way the pandemic changed the health promoting and healthcare-seeking behaviours of citizens in England.

Deconditioning is a deterioration in physical performance and is an important sign of new-onset disability and frailty. Age UK survey data, based upon people's self-reported well-being, suggest that older people have experienced physical deconditioning as well as cognitive decline (such as feeling forgetful and confused) following the social isolation and national lockdown measures imposed during the pandemic.

Falls and fractures are both associated with the new-onset of disability and frailty, and are used as proxy measures of frailty prevalence at a population level.[50]

Evidence of Effectiveness/best practice:

The British Geriatrics Society (BGS) 'Fit for Frailty' guideline recommends that older people should be assessed for frailty at all healthcare encounters using gait [walking] speed, the timed up and go test (TUGT) or the PRISMA 7 questionnaire.[51]

These three tests have been shown to be highly sensitive but only moderately specific for identifying frailty, meaning that they may identify more patients with frailty than actually have it. Combining two of these tests may reduce the number of false positive results.[52]

NICE guidelines relevant to frailty include:

NICE guidelines multimorbidity NG 56

Dementia, disability, and Frailty in later life NG 16

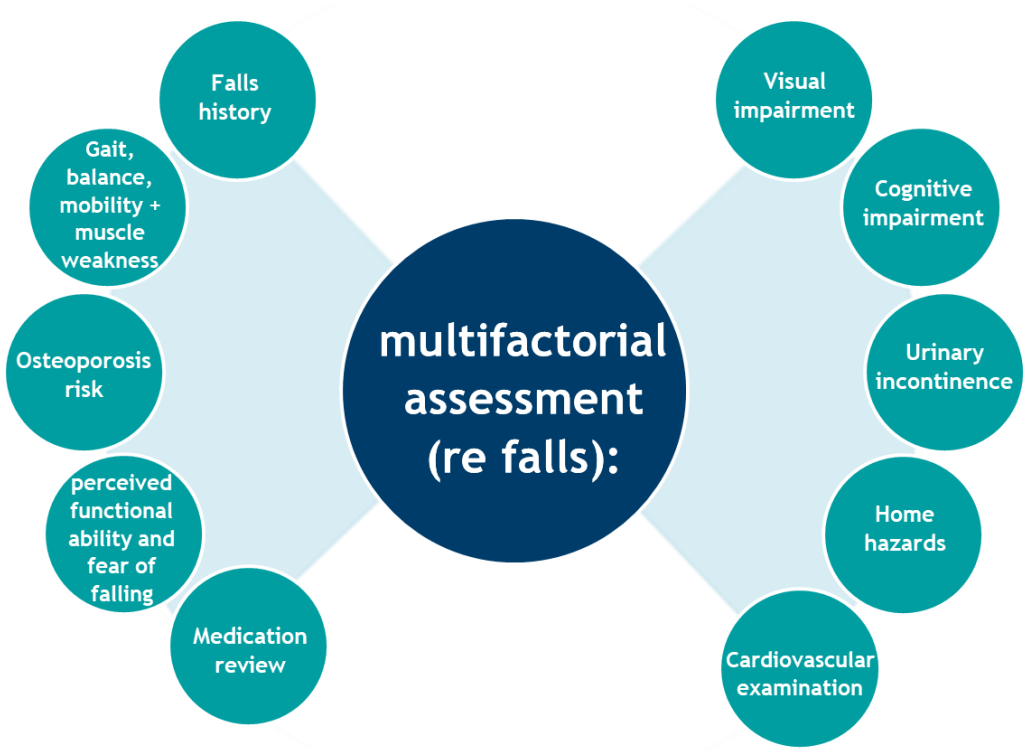
Falls in older people: assessing risk and prevention CG 161

This guideline is being updated in 2024.

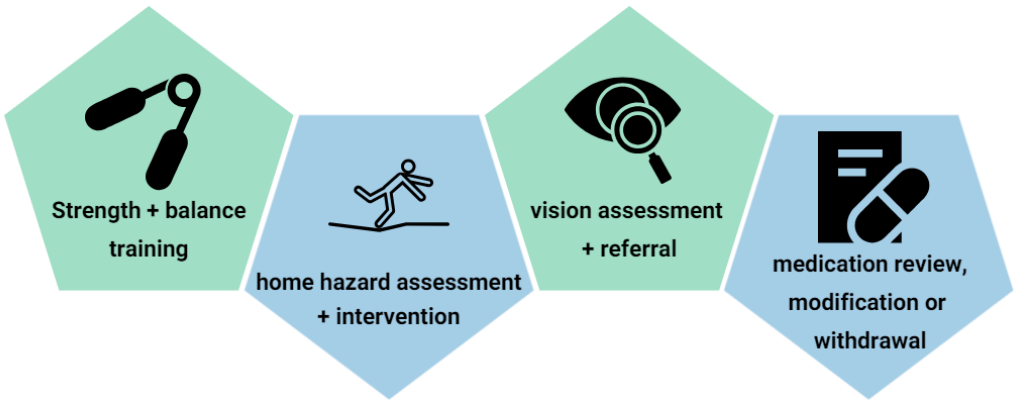
This guideline includes recommendations on:

- multifactorial risk assessment of older people who present for medical attention because of a fall, or report recurrent falls in the past year
- multifactorial interventions to prevent falls in older people who live in the community
- multifactorial risk assessment of older peoples' risk of falling during a hospital stay
- multifactorial interventions to prevent falls in inpatients at risk of falling

A summary of the multifactorial falls risk assessment of older people who present for medical attention because of a fall, or report recurrent falls is shown below:



NICE guidelines recommend that multifactorial interventions for frailty/falls should include the following four elements:



Other guidance includes:

- NHS England toolkit for general practice in supporting older people living with frailty
- British Geriatric Society Comprehensive Geriatric Assessment (CGA) toolkit for general practitioners and medical and healthcare professionals working in primary care settings
- National Institute of Health Research summary of reliable evidence about the effects of important interventions for practitioners and decision makers
- A new community rehabilitation and reablement model. Good practice guidance for integrated care boards (commissioners and providers)

What are our plans now and in the future?

Sussex Shared Delivery Plan (SSDP) Improving Lives Together has an ambition to help local people to age well by '*Helping older people to stay healthy and live independently for longer'* and by '*Reducing the number of older people who suffer falls*'.

The Health Outcomes Improvement Oversight Board (HOIOB) in NHS Sussex East, has identified 'Frailty and Healthy Ageing' as one of four key priority areas for improvement, in response to data reporting the high rates of falls admissions.

A HOIOB multi-agency workshop took place in November 2023, to explore the issues and opportunities for improvement for frailty and healthy ageing. A key outcome identified a gap in governance and oversight for this workstream, and one of the main recommendations was the need to identify a governance and oversight resource for both falls and frailty.'

Sussex Locally Commissioned Service: Frailty and End of Life Care for Non-Care Home Patients

The long-term aim of the Sussex Integrated Care Partnership will be to provide a comprehensive, countywide frailty service with GP practices, community providers working jointly and collaboratively together across the primary and secondary care interface, to provide a community-based service with both 'in-reach' and 'out-reach' components.

Frailty and end of life care for non care home patients | - NHS Sussex (ics.nhs.uk)

A locally commissioned service (LCS) enables Sussex GPs to provide a more comprehensive level of care than is specified in their GMS contract to moderately and severely frail people who are not living in a care home environment.

The service is designed to cover the enhanced aspects of clinical care of this group of patients and to foster a more pro-active approach to management, all of which are beyond the scope of essential services.

All Sussex Primary Care Networks and their GP practices have already signed up to provide the Enhanced Health in Care Homes (EHCH) PCN Directly Enhanced Services.

Conclusion

Frailty is a useful, broad concept which describes an increasing vulnerability to stressors and disordered maintenance of function [homeostasis] associated with the process of ageing. Promoting healthy ageing offers a chance to avoid or postpone the onset of frailty.[53]

For people at risk of developing frailty there are potentially preventable or modifiable risk factors and in the management of long-term conditions. Frailty is not an inevitable consequence of ageing, and it is possible to prevent or delay its onset.

Methods for robustly identifying frail patients individually, and for planning and delivering frailty appropriate care, need to be uniformly adopted. It is equally important to implement prompt health and social care interventions once these frailty risks have been identified.[54] A new service in the community will be offered by general practices in Sussex to achieve this.

New models of improving healthy ageing in primary care have been shown to have measurable benefits [for example, lower BMI in the obese and higher BMI in the undernourished, reduced GP contacts and reduced hospital.

The following summary about how information on the prevalence, measurement, and outcomes of frailty in the acute setting can inform policy, planning and care. This is adapted from Ref.[55]

Policy

- Staffing levels and skill mix calculations.
- Frailty training requirements
- Resourcing and service design

Service Planning

- Development of frailty care pathways
- Need for Comprehensive Geriatric Assessment and multidisciplinary team care
- Case-mix evaluation

Clinical Care

- Frailty measures as communication tools for handover and transfers
- Individualisation of acute treatment according to frailty status
- Risk-stratification for further needs assessment or specialised frailty care
- Enhanced discharge planning and strengthening of post discharge care
- Improved patient and caregiver experience including counselling about prognosis. Advanced care planning and power of attorney
- Readmission avoidance strategies

References:

Links to main evidence sources:

British Geriatric Society: frailty what's it all about

British Geriatric Society "Ft for Frailty" NHS England toolkit for general practice in supporting older people living with frailty

Scottish Improvement Hub Review of Frailty [includes links to Falls Screening Tool; Clinical Frailty Scale by Rockwood; the Frailty phenotype by Fried; the Timed Up and Go Test]

Gold Standard Framework (GSF) for people in the last 12 months of life

NICE guidelines Multimorbidity NG 56

NICE guidelines Dementia, disability, and Frailty in later life NG 16

Sussex LCS: Frailty and End of Life Care for Non-Care Home Patients

[1] Preventing frailty. NHS England, 2023.

[2] NIPP-CATU-Evaluation-Executive-Summary-2023.pdf (nihr.ac.uk)

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